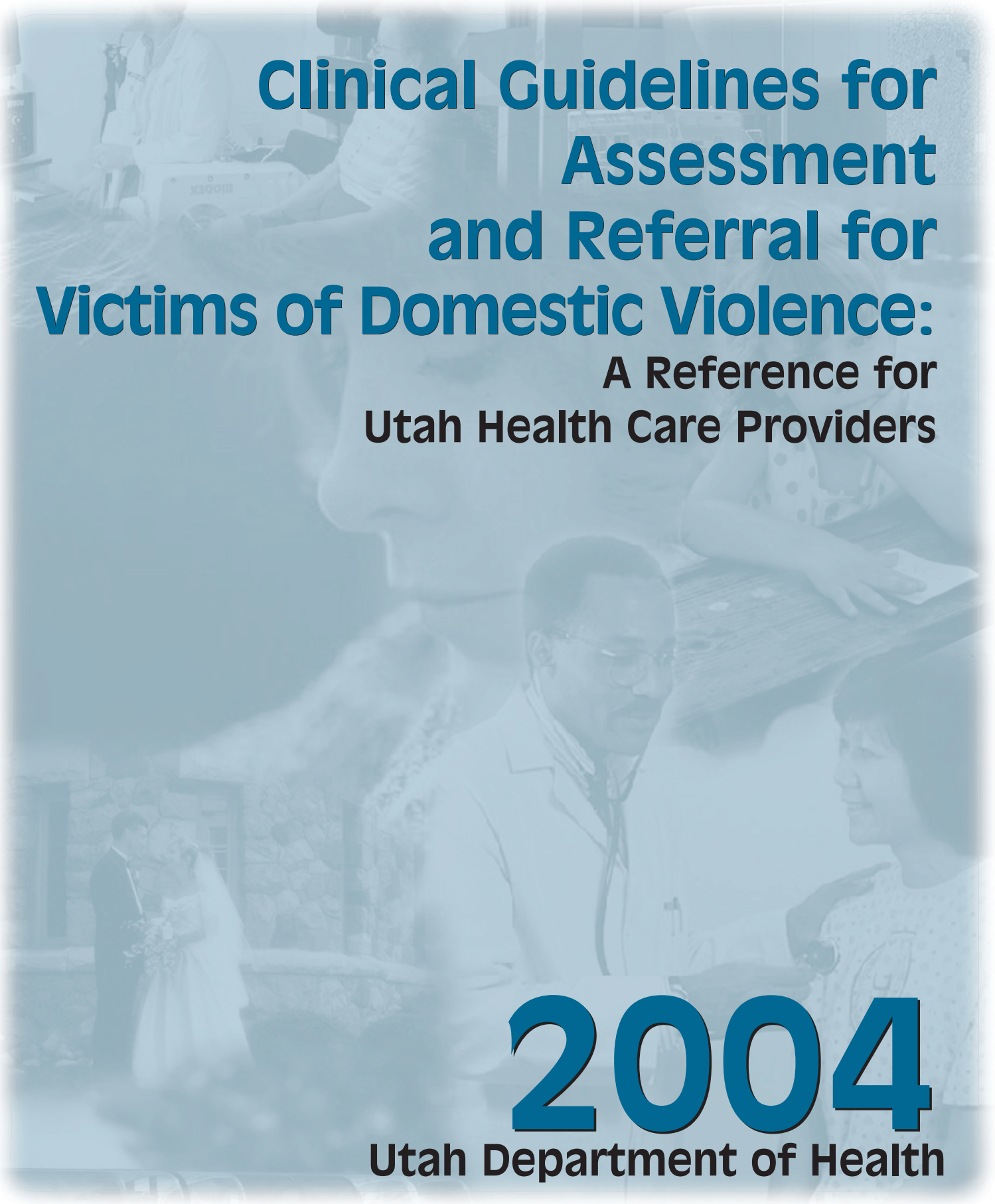

Clinical Guidelines for Assessment and Referral for Victims of Domestic Violence:

A Reference for Utah Health Care Providers

2004

Utah Department of Health

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VIPP

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UDVC
THERE'S NO EXCUSE FOR ABUSE

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Domestic Violence

Prevalence

Domestic violence (DV), also called intimate partner violence (IPV), is a serious problem plaguing the homes and health of millions of Americans. Every year, more than 1.5 million women and 834,700 men are physically assaulted and/or raped by their intimate partner (Centers for Disease Control, 2003). An estimated 20-30 percent of women and 7 percent of men have been physically assaulted and/or raped by an intimate partner in their lifetime (Campbell et al., 2003). While studies show that men are also victims of domestic violence, the majority of victims are women. One study found that of those who have been physically assaulted, 92 percent were women who had been assaulted by men (Campbell et al., 2003). In many cases the violence does not end with debilitating physical abuse, but escalates into homicide. From 1994-1999, in Utah, a current or former intimate partner perpetrated 49 percent of female homicides in Utah. These figures support previous reports that suggest "…violence against women is predominantly intimate partner violence" (Campbell et al., 2003).

The effects of domestic violence are both devastating and far-reaching and impact men, women, children, and the elderly. Domestic violence knows no limits and can be found in any socioeconomic level, race, religion, age group, and community. The total financial impact of domestic violence on communities is uncertain, but the estimated cost of treatment for battered women seeking medical attention is $1.8 billion each year (Centers for Disease Control, 2003).

Although the impact of domestic violence on the community continues to be explored, it is clear that women experiencing abuse, or who have experienced abuse, suffer physically and psychologically—beyond the actual episodes of violence. Health problems may persist even after the victim has left the abusive relationship. **Abused women commonly report adverse health effects such as chronic neck or back pain, arthritis, headaches, sexually transmitted diseases including HIV/AIDS, chronic pelvic pain, chronic irritable bowel syndrome, peptic ulcers, and a combination of indigestion, diarrhea, and constipation** (Coker et al., 2000). Domestic violence victims also have an increased risk of adverse mental health effects including depression, anxiety, traumatic and post-traumatic stress disorder, and suicide ideation (Danielson et al., 1998), (Stark et al., 1995), (Housekamp et al., 1998) and (Gelles et al., 1989). Such problems are often compounded by the use of alcohol and illicit drugs (Barkan et al., 2002).

Abused women are not the only victims of domestic violence who suffer negative health effects from abuse. Both children and the elderly experience abuse, neglect, and exploitation. In approximately 60 percent of homes where IPV takes place, child abuse also occurs (Edleson, 1999). Whether the child is an actual victim of physical abuse or a witness to it, children in homes where domestic violence occurs are more likely to experience post-traumatic stress disorder, chronic somatic problems, depression, and anxiety. They are also more prone to exhibit the following behaviors: violence toward peers, alcohol and drug abuse, suicide attempts, involvement in teenage prostitution, running away from home, and involvement in sexual assault crimes (Jaffe et al., 1995) and (Wolfe et al., 1995).

Because of the devastating effects and prevalence of domestic violence, action must be taken to decrease the enormity of the problem and to alleviate the suffering caused by abuse. Domestic violence is not an issue that can be solved overnight or with one specific intervention: It is a complicated health problem that must be addressed through a collaborative effort involving religious leaders, law enforcement, employers, health professionals, policy makers, legal professionals, educators, advocates, and friends of the abused (Centers for Disease Control Injury Report, 2003).

Domestic Violence

Definitions

Domestic Violence (DV), or Intimate Partner Violence (IPV)

A pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, or was, involved in an intimate or dating relationship and is aimed at establishing control by one partner over the other (Family Violence Prevention Fund, 1999).

Physical Abuse

Any forceful, physical behavior, which may include:

1. Pushing, slapping, hitting, shoving, biting, punching, kicking, or strangulation
2. Assault with a weapon
3. Holding, tying down, or restraining
4. Leaving partner in a dangerous place
5. Refusing to obtain medical help when partner is sick or injured
6. Restricting sleep or access to food and/or water

Emotional and Psychological Abuse

Any verbal/nonverbal form of communication used to control a partner, which may include :

1. Threats of harm or suicide
2. Physical and social isolation
3. Extreme jealousy and possessiveness
4. Intimidation
5. Degradation and humiliation
6. Name-calling and constant criticism, insults, and belittlement
7. False accusations and blame
8. Ignoring, dismissing, or ridiculing needs
9. Lying, breaking promises, and destroying trust
10. Driving fast and recklessly to frighten and intimidate
11. Restricting access to financial resources such as checkbook, money, car keys, etc.

Sexual Abuse

Any form of forced sex or sexual degradation, which may include:

1. Forcing sexual behaviors when partner is particularly vulnerable (e.g., asleep, drunk, intoxicated, not fully conscious, or afraid to say no)
2. Physically hurting partner during sex or assaulting partner's genitals
3. Criticizing or calling partner sexually degrading names
4. Treating partner as a sex object
5. Making partner perform sexual acts against his/her will
6. Limiting access to contraceptives
7. Forcing partner to watch or witness sexual acts performed by others (Fairview Health Services, 1995)

Elder Abuse

Prevalence

According to the 2002 U.S. Census, the elderly, defined as persons age 65 and older, numbered 35.6 million. This represents approximately 12.3 percent of the U.S. population or one in every eight Americans. **Utah has one of the fastest-growing older populations in the country.** It is forecasted that Utah's 65+ population will increase 165 percent by 2030 from the year 2000 (State of Utah, 2002).

Federal and State statutes require that vulnerable adults, who include the elderly and mentally or physically impaired adults, be protected from abuse, neglect and exploitation. Utah statute includes a mandatory reporting law that requires anyone who suspects abuse, neglect or exploitation of a vulnerable adult to report it to either law enforcement or Utah Adult Protective Services. Adult Protective Services (APS), within the Division of Aging and Adult Services, is in turn mandated to investigate allegations of abuse against any vulnerable adult.

In 2000, APS agencies nationwide received 472,813 reports of elder/adult abuse or mistreatment. Incidents of elder abuse are largely underreported to authorities. It is estimated that **only one in ten cases of elder abuse is ever reported to the proper authorities.** There may be a number of reasons that people fail to report suspected abuse.

In 2002, Utah APS investigated 2,139 referrals of abuse of vulnerable adults. Of these, 791 were substantiated. Of the substantiated cases, 53 percent were for neglect, 32 percent for abuse and 15 percent for exploitation. Of these cases, 64 percent of the victims were female and 55 percent were over the age of 70. In most cases, the perpetrator was a relative or family member of the victim (67 percent).

Definitions

Vulnerable Adult

Accepted referrals require an adult to be at risk due to an allegation of abuse, neglect, or exploitation and contain one of the following elements:

1. A person 65 years of age or older
2. A person who is 18 years of age or older and has a mental or physical impairment that substantially affects that person's ability to:
   - Provide personal protection
   - Provide necessities such as food, shelter, clothing, or mental or other health care
   - Obtain services necessary for health, safety, or welfare
   - Carry out the activities of daily living
   - Manage his/her own resources
   - Comprehend the nature and consequences of remaining in a situation of abuse, neglect, or exploitation.

Physical Abuse:

Any forceful, physical behavior, which may include:

1. Physical injury/harm
2. Unlawful restraint
3. Sexual abuse
4. Deprivation of life-sustaining treatment

Neglect:

1. Caretaker neglect (The caretaker is failing to provide for the basic needs of the elderly or disabled person)
2. Self-neglect (The elderly or diasabled is unable to provide their own basic needs)

Exploitation:

1. Financial
2. Criminal activity
3. Power of attorney/guardianship

The Health Care Professional's Role

Health care professionals have the unique opportunity and responsibility to identify victims of domestic violence and to refer and intervene on their behalf. Often health care providers are the first or only professionals to see the injuries of the abused, yet many victims of domestic violence move in and out of the health care system without identification or referrals (Schiavone, 1996). The development and implementation of policies and procedures, reinforced by staff education, may increase the rate of identification of battered adults (Coker et al., 2000) and (Danielson et al., 1998). As domestic violence recurs (Violence Policy Center, 2003) emergency department identification may interrupt the cycle of violence and help prevent further abuse.

Health professionals have gained a reputation as sources of comfort and care. Generally, patients trust their providers to make suggestions that will benefit their physical and mental well being. Such a relationship can open up avenues of communication that may otherwise have remained closed. This is why it is important for health care providers to ASK about the occurrence of domestic violence in the homes of their patients. In one independent study, the majority of women reported a willingness to reveal histories of abuse to health care professionals if asked directly by the professionals (Rodriguez, 1999). Victim advocates and others encourage health care professionals to take advantage of one-on-one situations with their clients to ask about violence, especially if they suspect abuse.

When health care providers fail to question patients about abuse, it is usually not because they do not care about their clients' safety, but because of existing or perceived barriers. Such barriers include (Rodriguez, 1999):

1. Cultural differences
2. Lack of privacy
3. Language differences
4. Lack of training on domestic violence
5. Lack of time
6. Lack of resources/referrals
7. Fear or discomfort in asking questions about domestic violence
8. Desire not to become involved in the issue with the patient

It is hoped that, despite these barriers, health care workers will make the asking of questions a routine practice and will recognize the benefits of identifying and referring domestic violence victims. Even when victims do not disclose information about the violence they are experiencing, **it is empowering for the victims to know there are people who care and are willing to help when they are ready to disclose.** In this small way, the simple act of asking can have a positive effect on the lives of these patients. At other times, the process of asking and intervening by health care professionals may save the life of their patient (Tjaden et al., 2000).

The Health Care Professional's Role

Bias

Before dealing with victims of domestic violence and elder abuse, it is important for the health care provider to evaluate his or her own feelings and prejudices. Victims of domestic violence have endured much – both physically and psychologically – and any indication of disbelief about the abuse may have a devastating effect on the patient's morale and confidence in divulging the truth about the violence he/she experiences.

When faced with the knowledge that any patient is being abused, **it is important that providers understand that, even though the victims may feel responsible, the acts of violence are not their fault.** The violence is the action and responsibility of the abuser. Domestic violence and elder abuse are crimes and no one deserves to be abused (Fairview Health Services, 1995).

The provider should be patient and empathetic when working with victims of domestic violence. Victims will often leave 7 to 12 times before leaving the abuser permanently (Stark et al, 1991). They stay for many reasons, including but not limited to: the lethality of the situation, the love they feel for their partners, to protect their children, and socioeconomic circumstances. **The provider should continue to support the victim regardless of her decision to leave or stay with the abuser.** The provider should also continue to document any occurrences of injuries.

The provider can empower victims by helping them realize that they are strong, resourceful, and clever to have gotten as far as they have under the circumstances. It is important that these compliments be honest and reasonable. The provider may want to suggest that patients keep a journal about the violence they experience if it. Victims will know if they would be able to do this safely.

It is natural for providers to want to present a solution to the problem; however, **by empowering patients to make their own choices, the provider will be helping patients realize their potential for taking control of their own lives.** It is important for the health care provider to be realistic and honest with the patient. **Suggesting that patients confront abusers about their intention to leave increases the lethality of the situation (Tjaden et al., 2000).**

Mandatory Reporting Laws

Health care providers are classified as mandatory reporters of abuse by the state of Utah. Mandatory reporting laws require reporting on instances of:

- Child abuse (call Child Protective Services) (800) 678-9399
- Elderly/disabled person abuse (call Adult Protective Services at (800) 371-7897)
- Any assault* (call local law enforcement or 911)

**An assault occurs when one person inflicts an injury on another person — this includes abuse. It is against the law even if an acquaintance or a loved one inflicted the injury.*

If an adult patient (excluding the elderly or disabled) presents with an injury that was inflicted by another person, "by means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state" the health care provider is required by law to report the injury to the authorities. It is important to note that inflicting any injury on another person with the intent of causing harm is a crime and considered a violation of the criminal statute of the state of Utah.

It is the health care provider's responsibility to contact law enforcement if a patient presents with an injury inflicted by another person. A patient may choose to lie to a provider or to the authorities regarding the causation of the injury, but this does not absolve the provider of the requirement. It is important to document that law enforcement has been contacted.

If a patient is being treated for an injury or illness that is not related to abuse, but discloses to the provider that he or she is a victim of domestic violence, the health care provider is not required to report to the authorities. It is, however, strongly recommended that providers refer the patient to a resource for the help they need to get out of the abusive relationship (see Appendix F).

Any health care provider who knowingly fails to report an injury inflicted by another person can be charged with a class B misdemeanor. The Utah Health Code, which includes definition, requirements and penalties, is provided in this section.

After a report is made, health care providers are mandated by HIPAA (Health Insurance Portability and Accountability Act) to inform the patient of the report. However, health care providers are absolved of this requirement if, in their professional judgment, they believe informing the individual would place them at risk of serious harm.

Privacy Rule

HIPAA Regulations

The Health Insurance Portability and Accountability Act (HIPAA) permits covered entities to disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence. Such disclosures can be made only to government agencies authorized by law to receive such reports, such as:

- Public health authorities
- Social service or protective services agencies
- Law enforcement authorities

HIPAA allows providers to disclose abuse that is required to be reported to comply with state law.

***Utah law allows for reporting of domestic violence to authorities without disclosure to the patient or their representatives prior to the report.**

The following is excerpted from the Health Insurance Portability and Accountability Act 42CFR Section 164.512(c).

Standard: Disclosures about victims of abuse, neglect or domestic violence.

(1) Permitted disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

Joint Commission on Accreditation of Healthcare Organizations

JCAHO STANDARD PE.1.9

Possible victims of abuse are identified using criteria developed by the hospital.

Intent of PE.1.9

Victims of abuse or neglect may come to a hospital through a variety of channels. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Nevertheless, hospital staff members need to know if a patient has been abused, as well as the extent and circumstances of the abuse, to give the patient appropriate care.

The hospital has objective criteria for identifying and assessing possible victims of abuse and neglect, and the criteria are used throughout the organization. Staff are to be trained in the use of these criteria. The criteria focus on observable evidence and not on allegation alone. They address at least the following situations:

- Physical assault
- Rape or other sexual molestation
- Domestic abuse
- Abuse or neglect of elders and children

When used appropriately by qualified staff members, the criteria prevent any action or question that could create false memories of abuse in the individual being assessed. Staff members are able to make appropriate referrals for victims of abuse and neglect. To help them do so, the hospital maintains a list of private and public community agencies that provide help for abuse victims. In addition, the assessment of victims of alleged or suspected abuse or neglect is conducted consistent with standard PE.8.

JCAHO STANDARD PC.3.10

Patients who may be victims of abuse or neglect are assessed (see standard RI.2.150).

Rationale for PC.3.10

Victims of abuse or neglect may come to a hospital in a variety of ways. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Staff needs to be able to identify abuse or neglect as well as the extent and circumstances of the abuse or neglect to give the patient appropriate care. Criteria for identifying and assessing victims of abuse or neglect should be used throughout the hospital. The assessment of the patient must be conducted within the context of the requirements of the law to preserve evidentiary materials and support future legal actions.

JCAHO STANDARD PE.8

Patients who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment process.

Intent of PE.8

As part of the initial screening and assessment process, information and evidentiary material(s) may be collected that could be used in future actions as part of the legal process. The hospital has specific and unique responsibilities for safeguarding such material(s).

Policies and procedures define the hospital's responsibility for collecting, retaining, and safeguarding information and evidentiary material(s). The following are documented in the patient's medical record:

- Consents from the patient, parent, or legal guardian, or compliance with other applicable law
- Collecting and safeguarding evidentiary material released by the patient
- Legally required notification and release of information to authorities
- Referrals made to private or public community agencies for victims of abuse.

Hospital policy defines these activities and specifies who is responsible for implementing them.

Compelling Reasons for Routine Screening

Domestic violence is a health care issue. It is a significant threat to the health and well being of the victims, as well as to those who may witness domestic violence. Homicide is the leading cause of death for women in the workplace and for African-American women ages 15 to 24 (Tuscano et al., 1996). It is the fourth leading cause of death for women under the age of 45 (Hoyert, 1997).

Medical professionals are often the first, and sometimes only professionals to see a victim of domestic violence. **Failing to diagnose abuse increases the patient's health risk and could further harm the patient by validating her sense of entrapment.**

To adhere to the American Medical Association's Principles of Medical Ethics, physicians must intercede in cases of domestic violence and elder abuse. Edmund Pellegrino and David Thomasma, bio-ethicists of the Council state, "The aim of medicine is to address not only the bodily assault that disease or an injury inflicts, but also the psychological, social, even spiritual dimensions of this assault. To heal is to make whole or sound, to help a person reconvene the powers of self and return, as far as possible, to his (or her) conceptions of a normal life" (American Medical Association, 1992). The American Medical Association Policy E-2.02 (2003) has issued guidelines for detecting and treating family violence. It states:

"Due to the prevalence and medical consequences of family violence, physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history. Physicians must also consider abuse in the differential diagnosis for a number of medical complaints, particularly when treating women.

"Physicians who are likely to have the opportunity to detect abuse in the course of their work have an obligation to familiarize themselves with protocols for diagnosing and treating abuse and with community resources for battered women, children, and elderly persons.

"Physicians also have a duty to be aware of societal misconceptions about abuse and prevent these from affecting the diagnosis and management of abuse. Such misconceptions include the belief that abuse is a rare occurrence; that abuse does not occur in 'normal' families; that abuse is a private problem best resolved without outside interference; and that victims may be responsible for the abuse against them."

By identifying and acknowledging the abuse, the physician may be helping to end the cycle of violence and increase the health and welfare of the patient. This simple intervention may begin a process whereby the victim may seek the necessary assistance to find safety.

> **The aim of medicine is to address not only the bodily assault that disease or an injury inflicts, but also the psychological, social, even spiritual dimensions of this assault.**
> **–AMA**

Utah Domestic Violence Council Recommendations

The Utah Domestic Violence Council has provided the following recommendations to professionals who may come in contact with victims of domestic violence in the health care setting.

AARRC

The Utah Domestic Violence Council, in an effort to lessen the incidence of domestic violence in Utah, asks all health care providers who may come in contact with a victim of domestic violence to recognize it as a crime and to:

Ask questions to determine if the patient has been abused. ROUTINELY ask your female patients over the age of 14 about domestic violence as part of the medical history or the physical exam.

Assess patient safety. Help the patient reduce the danger when the patient is discharged.

Remember domestic violence is a crime. Report any suspected abuse to law enforcement.

Refer the patient to specialists trained to help victims cope with all aspects of the abuse. If the patient discloses abuse, take the time to talk about options that are available. Provide the patient with names and telephone numbers of local shelters or advocates.

Chart the abuse and referrals. Document the patient's injuries thoroughly. Accurate, well-documented medical records are essential should an abusive situation end up in court.

Indicators of Abuse

Recognizing Abuse

Although abusive relationships may differ in dynamics from one couple to another, research has shown that there are basic dynamics and certain (high-risk factors) indicators of abuse. Listed below are injuries or conditions that should raise suspicion of abuse (Schiavone, 1996) and (Health Care Committee, 1993):

- Recent trauma history
- Injury to the head, neck, torso, breasts, abdomen, or genitals
- Bilateral or multiple injuries
- Unexplained injuries or injuries that are inconsistent with the patient's story
- Delay in seeking medical treatment
- Physical injury during pregnancy, especially on the breasts and abdomen
- Chronic pain symptoms for which no etiology is apparent
- Behavioral cues such as depression, suicide ideation, anxiety, sleep disorders, panic attacks, symptoms of post-traumatic stress disorder, and alcohol/substance abuse problems
- Overly protective, controlling partner, or a partner who refuses to leave patient
- Direct or indirect references to abuse
- Defensive wounds such as bruises/lacerations on backs of forearms, hand, etc.

Victim Dynamics: (Family Violence Prevention Fund, 2002)

- Often fearful of partner
- Often not allowed access to family, friends, or other support networks
- Often experiences reduced autonomy and/or, when they exercise autonomy, there are negative or abusive consequences
- Often feels guilty or wonders if he/she is to blame for his/her partner's violence
- May experience physical injuries and/or psychological problems
- Others have expressed concern about the victim's safety
- Takes blame for the violent episode(s)

Perpetrator Dynamics: (Family Violence Prevention Fund, 2002)

- Often controls access to money, property, and other shared commodities
- Often notably jealous of friends, family, co-workers, and others
- Scornful of partner's perspective
- Uses various forms of status to claim authority, knowledge, or power
- Often minimizes or explains his/her behavior, makes excuses, or becomes defensive
- Often vague about violent incidents
- May have a documented prior use of violence
- Often has defensive wounds caused by the victim (e.g., scratches or bite marks)
- Uses physical force against people or property

Screening For Abuse

Asking Questions

It is recommended that you make it a part of your routine to ask every female patient over the age of 14 about domestic violence on every visit, or any patient when there are possible signs of domestic violence. Normalize your questioning by explaining to the patient that the questions are a new personal standard or agency policy (if applicable). Most patients will not be offended if they know the questioning is policy or standard practice.

Before asking any questions regarding abuse, separate the patient from any visitors. (See section III-5.) If you are unable to do this, questioning may have to wait for a safer, more private situation. Never ask accompanying family or friends to act as an interpreter when there are questionable injuries. This includes interpreting for the deaf and/or for non-English speaking patients. Always use a professional interpreter.

If one of your patients is a victim of domestic violence and is willing to discuss the problem, **follow up on the issue at every visit if it is safe to do so and if he/she is willing. Respect the decision of the patient to discuss the problem or to remain silent about the issue.** Victims of domestic violence will discuss the problem when they are ready. If you suspect abuse, but your patient denies being abused, you may want to pose more than one question about the issue. Document the questions asked about abuse and your client's response. (See Section III, pages 7-8 for more information on reporting and documentation.)

When asking questions, remember that **the manner in which you ask the question is just as important as the question itself. Domestic violence is a very personal, sensitive subject and should be dealt with in a respectful, non-judgmental way.** How you ask the question will depend on your patient. Some people may respond better to direct questions, while others may need a question framed in such a way that will not make them defensive. You can soften questions by framing them.

> **Most patients will not be offended if they know the questioning is policy or standard practice.**

Screening For Abuse

Framing Questions

(Health Care Committee, 1993) and (Librett, et al., 2000):

- I know I have been seeing you in the clinic for a few years now, so this may seem strange, but I have started to ask all my patients about their relationships. What happens when you and your partner disagree?
- Relationships between adults are sometimes violent. Many women experience some kind of violence at home. What happens when you disagree at home? At any time have your verbal fights included any type of physical contact?
- I am concerned that your symptoms may have been caused by someone hurting you.
- Sometimes when others are overprotective and jealous, they react strongly and use physical force. Is this happening in your current relationship?
- You mentioned your partner loses his temper with the children. Does he lose his temper with you? Does he harm you in any way?

Direct Questions

(Health Care Committee, 1993) and (Librett, et al., 2000):

- Are you in a relationship with a person who physically hurts or threatens you?
- Are you safe at home?
- Has your partner or anyone in your home ever hit or hurt you in any way?
- Do you ever feel afraid of your partner or anyone in your home?
- Do you feel you are in danger?
- Did someone you are in a relationship with do this?
- Has your partner ever forced you to have sex when you didn't want to?
- I am concerned because I know that if you are in a relationship where violence occurs, it is likely to get worse. How can we help you?
- I am asking because I want you to have all the resources and information available for your use.

Questions to Avoid:

- Are you a battered woman?
- Does your husband beat you?
- You're not being hurt by your boyfriend, are you?
- Your child isn't witnessing the abuse, is she?

Steps for Questioning Patients About Abuse

1. Ask questions in a private, face-to-face setting.
2. Frame the question: "Because violence is so common in our lives today, I have begun asking all of my patients if they are in a relationship with someone who may be hurting or controlling them."
3. Directly question the patient: "Are you in a relationship or a home where someone hurts or threatens you?"

Separating the Patient From Visitors

The health care provider's primary concern should be for the safety of the staff and the victim. Never inquire about abuse in the presence of any person who accompanies the patient. Appearances can be deceiving. Do not assume that the person who accompanies the patient has the patient's best interest at heart.

Perpetrators of domestic violence are often very controlling and may not allow the victim to be alone for fear of disclosure. Providers should be prepared and have a plan for separating the perpetrator and the victim in a non-confrontational way that ensures the safety of the victim and the staff.

Ideas for Health Care Providers

- When possible, hang a sign in a specific area that indicates "patients only beyond this point."
- Take advantage of the privacy of the bathroom: Go into the bathroom with the patient when a urine sample is needed, or simply use the collection of the sample as an excuse to get the patient alone.
- Assure private time with the patient during tests (e.g., x-rays, MRIs, CT scans).
- If it is safe, provide the patient with educational information and other resources. Ask the patient what would happen if her partner found the resource materials, such as phone numbers and pamphlets.
- Identify code phrases that alert staff to call for security or law enforcement (e.g., "We need A, B, or C").

Ideas for Home Health Care Providers

- There may be an occasion when the patient is home alone. Use this opportunity to discuss abuse in the home. Keep in mind that the abuser may be someone you least expect (e.g., daughter, niece, grandchild).
- Phone the patient ahead of time to set up an appointment when the patient will be home alone (e.g., when other household members are at work, shopping, running errands).
- Use the framing questions to preface the reason for a private visit.
- Be creative. As a home health care provider, you often know your patients and the dynamics of their home lives.

Remember, if your patient is a "vulnerable adult" (see Section I, page 3) you are mandated to report all abuse, neglect, and exploitation. Your reporting rights ARE NOT limited to the existence of an injury caused by another person.

Patients ONLY Beyond This Point

DOCUMENTATION

Documenting Abusive Injuries

For medical records to provide evidence of violence and patterns of violence for legal proceedings, chart documentation must be accurate, legible, and thorough. Medical records can provide crucial evidence in support of the victim in court. Documentation should include (Librett, et al., 2000):

- Date and time of arrival
- Name, address, and phone number of anyone accompanying the patient
- Primary complaint
- Description of injury-causing event, including patient's own statements of how the injuries occurred (direct quotes)
- Patient's statements of past battering incidents (direct quotes)
- A detailed description of the injuries, including type, number, and location, (may want to record injuries on body charts)
- Complete medical history
- Relevant social history
- Laboratory and radiological results
- Name of health care professional who provided treatment
- Documentation that the patient was asked about DV and the patient's response
- Documentation that injuries were reported to law enforcement (see Appendix A)
- Documentation of resource information given for aftercare (e.g., shelters, counseling, victim advocates, etc.)
- Consent forms for any photographs taken
- Record of non-bodily evidence of abuse, such as torn clothing or damaged jewelry
- Name of translator used, if applicable

You may want to consider establishing a way of flagging charts that contain domestic violence cases so that the information in the charts will be better protected, especially from the abuser. For example, an unlabeled, colored sticker could be used to flag staff and an abuser would not know what the sticker represents.

Reporting Abuse

Reporting to Authorities

Providers are under legal obligation to report abuse. **In Utah, providers cannot incur civil or criminal liability for reporting cases of suspected abuse.** Health care professionals cannot be discharged, suspended, disciplined, or harassed for making a report (Fairview Health Services, 1995) and (Librett, et al., 2000).

However, penalties can be pursued against providers who fail to report suspected or confirmed cases of abuse. Such consequences can include: being charged with a misdemeanor, time in jail, and both personal and corporate fines (Librett, et al., 2000).

When reporting incidents of abuse, report to the municipal or county law enforcement agency where the injury occurred. If abuse occurs in more than one jurisdiction, notify the authorities closest and report the injuries that took place in that jurisdiction. It is required that you report by telephone or by another form of spoken communication (Librett, et al., 2000). Again, it is important to document that the case was reported.

Documentation of the report should include:

- Which law enforcement agency was contacted
- What phone number was called
- When the contact was made
- Name of the law enforcement officer spoken with

What to include in the report (refer to Utah Statute 26-23a-2):

- Name and address of the injured person
- Injured person's whereabouts, if known
- Character and extent of the person's injuries
- Name, address, and phone number of the person making the report

After the Report

After a report of abuse is made to law enforcement, the health care provider is required to inform the patient of the report, according to the Privacy Rule (HIPAA). However, if the health care provider, in the exercise of professional judgment, believes informing the individual would place the patient in greater danger, he/she is absolved of this requirement.

Health care providers should never dictate a specific course of action to the patient. In abusive relationships, the victim has always been told what to do. By offering information to patients, the provider will be giving them the tools to make choices for themselves.

The patient may, understandably, become distressed when the health care provider informs the patient of a domestic violence report. The patient may beg the provider to forgo notifying the authorities. She may be afraid that her children will be removed or that she will be in more danger once the police are involved. Being supportive but honest and straightforward is the best response. Explain to the patient the legal requirements of health care providers. Use this opportunity to educate the patient about domestic violence. Some important messages to convey to the patient are:

- Domestic violence is cyclical and may intensify, causing more harm to the victim.
- Abuse is not unique. According to a 2003 report released by LDS Hospital, one in ten female patients being treated in the emergency room reported being a victim of domestic violence patients in the previous year. Nearly 40 percent of women indicated they had been abused during their lifetime (Allen, 2003).
- Abuse is not the victim's fault and she is not responsible for the violence inflicted upon her.
- There are health risks associated with violence not only for her but also for her children. Domestic violence is a crime for which there are solutions.

After the Report

It is important for the health care provider to be supportive of the patient after a report to authorities is made. The patient may be nervous, apprehensive or afraid. Some suggestions for supporting the victim after the report is made include:

- Contacting a crisis worker or social worker within your organization if one is available.
- Contacting a victim advocate on behalf of the victim (Appendix F).
- Providing the victim with resources and referral numbers.
- Offering to contact clergy of the victim's faith. Many hospitals have clergy on-site who may be able to offer comfort and resources to the victim.
- Discussing with the victim her level of safety and, if feasible, developing a safety plan. Brochures on safety planning are available from the Utah Domestic Violence Council at (801) 521-5544.

Many victim advocate programs have packets that contain helpful information for victims of domestic violence. However, some patients may not be willing to speak with a victim advocate. Health care agencies are encouraged to acquire similar information to distribute in the event the victim refuses a referral to a victim advocate or shelter. These packets should include:

- A business card with the victim advocate's phone number and an after-hours crisis phone number that will automatically page the on-call advocate.
- A safety plan. Safety plan brochures may be obtained from the Utah Domestic Violence Council at (801) 521-5544.
- Phone numbers and addresses of domestic violence shelters in the area.
- Information on protective orders and how to obtain one.
- Resource lists that provide information on emergency shelters, food, crisis nurseries, health clinics, alcohol and drug detoxification centers, legal help, support groups, and counseling.
- A crime victim reparation application.
- A risk of danger form.
- A victim impact statement.
- A guide to the criminal justice system (court process).

Local victim advocate programs will be helpful in obtaining copies of this information. A list of victim advocate programs is provided in Appendix F.

Summary of Resources

Resources

After identifying and documenting abuse, health care professionals should provide a referral to a local domestic violence shelter or victim advocate program. As a medical professional caring for domestic violence patients, it may not be necessary to be aware of every resource available. However, it is recommended you refer your patients to at least one resource for further assistance. Victim advocate programs and domestic violence shelters have a wealth of helpful information for those living with domestic violence. It is important to provide victims with a means to access help. Some resources are listed below:

- A Domestic Violence Information Line is available from 8:30 a.m. to 9:00 p.m., seven days a week. The number is **(800) 897-LINK**. The line is staffed by caring professionals who are knowledgeable about local shelters and advocate programs.
- A Web site containing information and referral numbers is available at **www.informationandreferral.org**.
- A 24-hour-a-day, rape and sexual assault information and crisis line is available. Call **(888) 421-1100** from anywhere in the state of Utah to reach programs in your area.
- Appendix F contains contact information for community resources available for each geographic area of the state of Utah.
- Shelters are accessible 24 hours a day for information, victim advocacy, or housing for victims of abuse (see Appendix F).

Victim Advocate Programs

Health care providers are strongly encouraged to contact a victim advocate as soon as a report is made. Victim advocates are trained to support victims and help them through the process of making a report. They also assist domestic violence victims and their families with finding social service resources in the community such as temporary shelter, medical assistance, childcare, transportation, and employment/education counseling. Often, victim advocates will respond to the hospital immediately. The goal of a victim advocate is to give the victim options, emotional support, and education on domestic violence, in addition to providing resources to help them take the steps necessary to become independent, functioning individuals. **Advocate programs address the immediate needs of victims of crime by responding to hospitals, helping victims through the judicial system, and providing emotional support.** Their knowledge of court processes, the preparation of safety plans and updated information on arraignments, pre-trials, and hearings are also key services. Victim advocate programs help victims fill out forms for Crime Victim Reparations, protective orders, and other documents that may be related to the case.

Shelters

The goal of domestic violence shelters is to provide all victims of domestic violence with resources and options to help them break the cycle of violence. These shelters provide short-term emergency shelter and support services for victims and their children at no cost to the victim. Shelters provide clothing, food, and other needed items. Most shelters provide crisis counseling, weekly support groups, individual counseling, and referrals to other agencies in their communities. Shelters also provide crisis counseling and supportive services to non-shelter clients.

Shelters/safe houses are available to victims of domestic violence 24 hours a day, seven days a week. When referring a victim to a shelter, remember that shelter staff prefer to speak to the victims personally prior to their arrival.

Allen, T.L., Stevens, M.H., Olson, L.M., Koplin, J.T., Keddington, R.K., Chan, K.J., Handrahan, D.L., Eggar, M.J., Nelson, J.C. (2003). **Prevalence of Intimate Partner Abuse and Suicidal Ideation among Women in a Community Emergency Department.** (Available from Todd L. Allen, Department of Emergency Medicine, LDS Hospital, 8th Avenue and C Street, Salt Lake City, UT 84143).

American Medical Association. Council on Ethical and Judicial Affairs. (1992). **Physicians and domestic violence - ethical considerations.** Journal of the American Medical Association 267: 3190-3193.

American Medical Association Policy E-2.02. (2003). **Domestic Violence Intervention Report.** [online]. Available at www.ama-assn.org/ama/noindex/category/11760.html.

American Medical Association. (1992). **Diagnostic and Treatment Guidelines on Domestic Violence.** 4-20.

American Medical Association. (1992). **Diagnostic and Treatment Guidelines on Elder Abuse and Neglect.** 4-42.

Barkan, H., Farley, M., & Minkof, J. (2002). **Mammography Screening and Domestic Violence.** Abstract presented at the National Conference on Health Care and Domestic Violence, Atlanta, GA.

Campbell JC, Sharps P, Laughon, K, Webster D, Manganello J, Schollenberger J, Koziol-McLain J, Block CR, Campbell D, Curry MA, Glass N, Gary F, McFarlane J, Sachs C, Ulrich Y, Wilt SA, Xu X, and Frye VA. (2003). **Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study.** American Journal of Public Health, (7), 1089-98.

Centers for Disease Control. (2003). **Intimate Partner Violence Surveillance. Centers for Disease Control Injury Center.** [online]. Available: www.cdc.gov/ncipc/pub-res/ipv_surveillance/06_Section1.htm.

Centers for Disease Control. (2003). **Intimate Partner Violence.** National Center for Injury Prevention and Control. [online]. Available: www.cdc.gov/ncipc/factsheets/ipvfacts.htm

Code of Federal Regulations. (2003). **Health Insurance Portability and Accountability Act.** (Title 45, Vol 1, sec. 164, Subpart E).

Coker, A., Smith, P., Bethea, L., King, M., & McKeown, R. (2000). **Physical Health Consequences of Physical and Psychological Intimate Partner Violence.** Archives of Family Medicine, 9.

Danielson, K., Moffit, T., Caspi, A., & Silva, P. (1998). **Co-morbidity Between Abuse of an Adult and DSM-III-R Mental Disorders: Evidence From an Epidemiological Study.** American Journal of Psychiatry, 155 (1).

Edleson, J.L. (1999). **The overlap between child maltreatment and woman battering.** Violence Against Women 5(2), 134-154.

Fairview Health Services. **Womankind Policies and Procedures.** Fairview Health System 1995. Minneapolis, MN.

Family Violence Prevention Fund. (2002). **National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings** (Appendix D). Family Violence Prevention Fund.

Family Violence Prevention Fund. **Preventing Domestic Violence: Clinical Guidelines on Routine Screening.** Family Violence Prevention Fund 1999. San Francisco, CA.

Gelles, R.J., & Harrop, J.W. (1989). **Violence, battering, and psychological distress among women.** Journal of Interpersonal Violence 4 (1).

Health Care Committee of the San Francisco Domestic Violence Council. (1993). **San Francisco Domestic Violence Health Care Protocol.** June 1993.

Health Insurance Portability Accountibility Act (2003) **45CFR165.512(c)**.

Housekamp, B.M., & Foy, D. (1991). **The assessment of posttraumatic stress disorder in battered women.** Journal of Interpersonal Violence 6 (3).

Jaffe, P., & Sudermann, M. (1995). **Child Witness of Woman Abuse: Research and Community Responses in Stith, S., & Straus, M. Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions. Families in Focus Services, Vol II.**

Librett, A. & Searle, N. (2000). **Guidelines for Assessment, Treatment and Referral for Victims of Partner Abuse.** Utah Department of Health.

Rodriguez, M.A, Bauer, H.M., McLoughlin, E., & Grumbach, K. (1999). **Screening and Intervention for Intimate Partner Abuse.** Journal of the American Medical Association. 282 (5).

Schiavone, F.M. (1996). **My Experience Screening in the Emergency Department.** Health Alert. Spring, 4(1).

Schornstein, S. L, (1997). **Domestic Violence and Health Care.** California: Sage Publications.

Stark, E., & Flitcraft, A. (1995). **Killing the beast within: Woman battering and female suicidality.** International Journal of Health Sciences, 25 (1).

Stark, E., & Flitcraft, A.H. Spouse Abuse. In: Rosenberg, M.L, & Fenley, M.A. **Violence in America: a public health approach.** New York: Oxford University Press, 1991:138-9.

State of Utah Division of Aging and Adult Services. (2002). **Offering Choices for Independence.** Annual Report., 3-27.

U.S. Census Bureau. (2002). **Statistical Abstract of the United States.** U.S. Census Bureau. 1373.

Tjaden, P., & Thoennes, N., (2000). **Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women.** National Institute of Justice.

Violence Policy Center. (2003). **When Men Murder Women: An Analysis of 2001 Homicide Data.** Washington D.C., October 2003.

Wolfe, D.A., Wekerle, C., Reitzel, D., & Gough, R. (1995). **Strategies to address violence in the lives of high risk youth.** In Peled, E., Jaffe, P.G., & Edleson, J.L. **Ending the Cycle of Violence: Community Responses to Children of Battered Women.**

Appendix A: Utah Health Code

Adult Abuse Statute

UTAH HEALTH CODE CHAPTER 26-23a
INJURY REPORTING BY HEALTH CARE PROVIDERS

26-23a-1. Definitions

As used in this chapter:
(1) "Health care provider" means any person, firm, corporation, or association which furnishes treatment or care to persons who have suffered bodily injury, and includes hospitals, clinics, podiatrists, dentists and dental hygienists, nurses, nurse practitioners, physicians and physicians' assistants, osteopathic physicians, naturopathic practitioners, chiropractors, acupuncturists, paramedics, and emergency medical technicians.
(2) "Injury" does not include any psychological or physical condition brought about solely through the voluntary administration of prescribed controlled substances.
(3) "Law enforcement agency" means the municipal or county law enforcement agency:

(a) having jurisdiction over the location where the injury occurred; or

(b) if the reporting health care provider is unable to identify or contact the law enforcement agency with jurisdiction over the injury, "law enforcement agency" means the agency nearest to the location of the reporting health care provider.
(4) "Report to a law enforcement agency" means to report, by telephone or other spoken communication, the facts known regarding an injury subject to reporting under Section 26-23a-2 to the dispatch desk or other staff person designated by the law enforcement agency to receive reports from the public.

26-23a-2. Injury reporting requirements by health care provider – Contents of report.

(1) (a) Any health care provider who treats or cares for any person who suffers from any wound or other injury inflicted by the person's own act or by the act of another by means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state, shall immediately report to a law enforcement agency the facts regarding the injury.

(b) The report shall state the name and address of the injured person, if known, the person's whereabouts, the character and extent of the person's injuries, and the name, address, and telephone number of the person making the report.
(2) A health care provider may not be discharged, suspended, disciplined, or harassed for making a report pursuant to this section.
(3) A person may not incur any civil or criminal liability as a result of making any report required by this section.
(4) A health care provider who has personal knowledge that the report of a wound or injury has been made in compliance with this section is under no further obligation to make a report regarding that wound or injury under this section.

26-23a-3. Penalties

Any health care provider who intentionally or knowingly violates any provision of Section 26-23a-2 is guilty of a class B misdemeanor.

76-5-III. Abuse, Neglect and Exploitation of an Elder or Disabled Adult

Abuse, neglect, or exploitation of a vulnerable adult – Penalties.

(1) As used in this section:

(a) "Abandonment" means a knowing or intentional action or inaction, including desertion, by a person or entity acting as a caretaker for a vulnerable adult that leaves the vulnerable adult without the means or ability to obtain necessary food, clothing, shelter, or medical or other health care.

(b) "Abuse" means:

(i) attempting to cause harm, intentionally or knowingly causing harm, or intentionally or knowingly placing another in fear of imminent harm;

(ii) causing physical injury by knowing or intentional acts or omissions;

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(iii) unreasonable or inappropriate use of physical restraint, medication, or isolation that causes or is likely to cause harm to a vulnerable adult that is in conflict with a physician's orders or used as an unauthorized substitute for treatment, unless that conduct furthers the health and safety of the adult; or

(iv) deprivation of life-sustaining treatment, except:

(A) as provided in Title 75, Chapter 2, Part 11, Personal Choice and Living Will Act; or

(B) when informed consent, as defined in this section, has been obtained.

(c) "Business relationship" means a relationship between two or more individuals or entities where there exists an oral or written agreement for the exchange of goods or services.

(d) "Caretaker" means any person, entity, corporation, or public institution that assumes the responsibility to provide a vulnerable adult with care, food, shelter, clothing, supervision, medical or other health care, or other necessities. "Caretaker" includes a relative by blood or marriage, a household member, a person who is employed or who provides volunteer work, or a person who contracts or is under court order to provide care.

(e) "Deception" means:

(i) a misrepresentation or concealment:

(A) of a material fact relating to services rendered, disposition of property, or use of property intended to benefit a vulnerable adult;

(B) of the terms of a contract or agreement entered into with a vulnerable adult; or

(C) relating to the existing or preexisting condition of any property involved in a contract or agreement entered into with a vulnerable adult; or

(ii) the use or employment of any misrepresentation, false pretense, or false promise in order to induce, encourage, or solicit a vulnerable adult to enter into a contract or agreement.

(f) "Elder adult" means a person 65 years of age or older.

(g) "Endeavor" means to attempt or try.

(h) "Exploitation" means the offense described in Subsection (4).

(i) "Harm" means pain, mental anguish, emotional distress, hurt, physical or psychological damage, physical injury, suffering, or distress inflicted knowingly or intentionally.

(j) "Informed consent" means:

(i) a written expression by the person or authorized by the person, stating that the person fully understands the potential risks and benefits of the withdrawal of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health, and that the person desires that the services be withdrawn. A written expression is valid only if the person is of sound mind when the consent is given, and the consent is witnessed by at least two individuals who do not benefit from the withdrawal of services; or

(ii) consent to withdraw food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health, as permitted by court order.

(k) "Intimidation" means communication conveyed through verbal or nonverbal conduct which threatens deprivation of money, food, clothing, medicine, shelter, social interaction, supervision, health care, or companionship, or which threatens isolation or harm.

(l) "Isolation" means knowingly or intentionally preventing a vulnerable adult from having contact with another person by:

(A) preventing the vulnerable adult from receiving visitors, mail, or telephone calls, contrary to the express wishes of the vulnerable adult, including communicating to a visitor that the vulnerable adult is not present or does not want to meet with or talk to the visitor, knowing that communication to be false;

(B) physically restraining the vulnerable adult in order to prevent the vulnerable adult from meeting with a visitor; or

(C) making false or misleading statements to the vulnerable adult in order to induce the vulnerable adult to refuse to receive communication from visitors or other family members.

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(ii) The term "isolation" does not include an act intended to protect the physical or mental welfare of the vulnerable adult or an act performed pursuant to the treatment plan or instructions of a physician or other professional advisor of the vulnerable adult.

(m) "Lacks capacity to consent" means an impairment by reason of mental illness, developmental disability, organic brain disorder, physical illness or disability, chronic use of drugs, chronic intoxication, short-term memory loss, or other cause to the extent that a vulnerable adult lacks sufficient understanding of the nature or consequences of decisions concerning the adult's person or property.

(n) "Neglect" means:

(i) failure of a caretaker to provide nutrition, clothing, shelter, supervision, personal care, or dental or other health care, or failure to provide protection from health and safety hazards or maltreatment;

(ii) failure of a caretaker to provide care to a vulnerable adult in a timely manner and with the degree of care that a reasonable person in a like position would exercise;

(iii) a pattern of conduct by a caretaker, without the vulnerable adult's informed consent, resulting in deprivation of food, water, medication, health care, shelter, cooling, heating, or other services necessary to maintain the vulnerable adult's well being;

(iv) intentional failure by a caretaker to carry out a prescribed treatment plan that results or could result in physical injury or physical harm; or

(v) abandonment by a caretaker.

(o) "Physical injury" includes damage to any bodily tissue caused by non-therapeutic conduct, to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition. "Physical injury" includes skin bruising, a dislocation, physical pain, illness, impairment of physical function, a pressure sore, bleeding, malnutrition, dehydration, a burn, a bone fracture, a subdural hematoma, soft tissue swelling, injury to any internal organ, or any other physical condition that imperils the health or welfare of the vulnerable adult and is not a serious physical injury as defined in this section.

(p) "Position of trust and confidence" means the position of a person who:

(i) is a parent, spouse, adult child, or other relative by blood or marriage of a vulnerable adult;

(ii) is a joint tenant or tenant in common with a vulnerable adult;

(iii) has a legal or fiduciary relationship with a vulnerable adult, including a court-appointed or voluntary guardian, trustee, attorney, or conservator; or

(iv) is a caretaker of a vulnerable adult.

(q) "Serious physical injury" means any physical injury or set of physical injuries that:

(i) seriously impairs a vulnerable adult's health;

(ii) was caused by use of a dangerous weapon as defined in Section 76-1-601;

(iii) involves physical torture or causes serious emotional harm to a vulnerable adult; or

(iv) creates a reasonable risk of death.

(r) "Sexual exploitation" means the production, distribution, possession, or possession with the intent to distribute material or a live performance depicting a nude or partially nude vulnerable adult who lacks the capacity to consent, for the purpose of sexual arousal of any person.

(s) "Undue influence" occurs when a person uses the person's role, relationship, or power to exploit, or knowingly assist or cause another to exploit, the trust, dependency, or fear of a vulnerable adult, or uses the person's role, relationship, or power to gain control deceptively over the decision making of the vulnerable adult.

(t) "Vulnerable adult" means an elder adult, or an adult 18 years of age or older who has a mental or physical impairment which substantially affects that person's ability to:

(i) provide personal protection;

(ii) provide necessities such as food, shelter, clothing, or medical or other health care;

(iii) obtain services necessary for health, safety, or welfare;

(iv) carry out the activities of daily living;

(v) manage the adult's own resources; or

(vi) comprehend the nature and

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consequences of remaining in a situation of abuse, neglect, or exploitation.

(2) Under any circumstances likely to produce death or serious physical injury, any person, including a caretaker, who causes a vulnerable adult to suffer serious physical injury or, having the care or custody of a vulnerable adult, causes or permits that adult's person or health to be injured, or causes or permits a vulnerable adult to be placed in a situation where the adult's person or health is endangered, is guilty of the offense of aggravated abuse of a vulnerable adult as follows:

(a) if done intentionally or knowingly, the offense is a second degree felony;

(b) if done recklessly, the offense is third degree felony; and

(c) if done with criminal negligence, the offense is a class A misdemeanor.

(3) Under circumstances other than those likely to produce death or serious physical injury any person, including a caretaker, who causes a vulnerable adult to suffer harm, abuse, or neglect; or, having the care or custody of a vulnerable adult, causes or permits that adult's person or health to be injured, abused, or neglected, or causes or permits a vulnerable adult to be placed in a situation where the adult's person or health is endangered, is guilty of the offense of abuse of a vulnerable adult as follows:

(a) if done intentionally or knowingly, the offense is a class A misdemeanor;

(b) if done recklessly, the offense is a class B misdemeanor; and

(c) if done with criminal negligence, the offense is a class C misdemeanor.

(4) (a) A person commits the offense of exploitation of a vulnerable adult when the person:

(i) is in a position of trust and confidence, or has a business relationship, with the vulnerable adult or has undue influence over the vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, credit, assets, or other property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the adult's property, for the benefit of someone other than the vulnerable adult;

(ii) knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, or assists another in obtaining or using or endeavoring to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of his property for the benefit of someone other than the vulnerable adult;

(iii) unjustly or improperly uses or manages the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult;

(iv) unjustly or improperly uses a vulnerable adult's power of attorney or guardianship for the profit or advantage of someone other than the vulnerable adult;

(v) involves a vulnerable adult who lacks the capacity to consent in the facilitation or furtherance of any criminal activity; or

(vi) commits sexual exploitation of a vulnerable adult.

(b) A person is guilty of the offense of exploitation of a vulnerable adult as follows:

(i) if done intentionally or knowingly and the aggregate value of the resources used or the profit made is or exceeds $5,000, the offense is a second degree felony;

(ii) if done intentionally or knowingly and the aggregate value of the resources used or the profit made is less than $5,000 or cannot be determined, the offense is a third degree felony;

(iii) if done recklessly, the offense is a class A misdemeanor; or

(iv) if done with criminal negligence, the offense is a class B misdemeanor.

(5) It does not constitute a defense to a prosecution for any violation of this section that the accused did not know the age of the victim.

(6) An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, non-medical forms of healing in lieu of medical care.

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76-5-111.1. Reporting requirements

(1) Any person, including but not limited to, a social worker, physician, psychologist, nurse, teacher, or employee of a private or public facility serving adults, who has reason to believe that any disabled or elder adult has been the subject of abuse, emotional or psychological abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or local office of Adult Protective Services within the Department of Human Services, Division of Aging and Adult Services.
(2) Anyone who makes that report in good faith is immune from civil liability in connection with the report.
(3) (a)When the initial report is made to a peace officer or law enforcement agency, and the disabled or elder adult requires protection, the officer or agency shall immediately notify the nearest local office of Adult Protective Services and that office shall coordinate its investigation with law enforcement, and provide protection to the disabled or elder adult as necessary.

(b) When the initial report involves a resident of a long-term care facility, as defined in Section 62A-3-202, the local long-term care ombudsman within the Department of Human Services, Division of Aging and Adult Services, shall be immediately notified. The ombudsman and the local Adult Protective Services office shall cooperate in conducting the investigation.

(c) When the initial report or investigation by an Adult Protective Services office indicates that criminal abuse, neglect, or exploitation, as defined in Section 76-5-111 has occurred, or that any other criminal offense against a disabled or elder adult has occurred, the local Adult Protective Services office shall immediately notify the local law enforcement agency. That law enforcement agency shall initiate an investigation in cooperation with the local Adult Protective Services office.
(4) A person who is required to report suspected abuse, emotional or psychological abuse, neglect, or exploitation of a disabled or elder adult under Subsection (1), and who willfully fails to do so, is guilty of a class B misdemeanor fines these activities and specifies who is responsible for implementing them.

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Utah Code: Cohabitant Abuse Procedures Act

77-36-1. Definitions.

As used in this chapter:

(1) "Cohabitant" has the same meaning as in Section 30-6-1.

(2) "Domestic violence" means any criminal offense involving violence or physical harm or threat of violence or physical harm, or any attempt, conspiracy, or solicitation to commit a criminal offense involving violence or physical harm, when committed by one cohabitant against another. "Domestic violence" also means commission or attempt to commit, any of the following offenses by one cohabitant against another:

(a) aggravated assault, as described in Section 76-5-103;

(b) assault, as described in Section 76-5-102;

(c) criminal homicide, as described in Section 76-5-201;

(d) harassment, as described in Section 76-5-106;

(e) telephone harassment, as described in Section 76-9-201;

(f) kidnaping, child kidnaping, or aggravated kidnaping, as described in Sections 76-5-301, 76-5-301.1, and 76-5-302;

(g) mayhem, as described in Section 76-5-105;

(h) sexual offenses, as described in Title 76, Chapter 5, Part 4, and Title 76, Chapter 5a;

(i) stalking, as described in Section 76-5-106.5;

(j) unlawful detention, as described in Section 76-5-304;

(k) violation of a protective order or ex parte protective order, as described in Section 76-5-108;

(l) any offense against property described in Title 76, Chapter 6, Part 1, 2, or 3;

(m) possession of a deadly weapon with intent to assault, as described in Section 76-10-507;

(n) discharge of a firearm from a vehicle, near a highway, or in the direction of any person, building, or vehicle, as described in Section 76-10-508;

(o) disorderly conduct, as defined in Section 76-9-102, if a conviction of disorderly conduct is the result of a plea agreement in which the defendant was originally charged with any of the domestic violence offenses otherwise described in this Subsection (2). Conviction of disorderly conduct as a domestic violence offense, in the manner described in this Subsection (2)(o), does not constitute a misdemeanor crime of domestic violence under 18 U.S.C. Section 921, and is exempt from the provisions of the federal Firearms Act, 18 U.S.C. Section 921 et seq.; or

(p) child abuse as described in Section 76-5-109.1.

(3) "Victim" means a cohabitant who has been subjected to domestic violence.

77-36-2.1. Duties of law enforcement officers– Notice to victims.

(1) A law enforcement officer who responds to an allegation of domestic violence shall use all reasonable means to protect the victim and prevent further violence, including

(a) taking the action that, in the officer's discretion, is reasonably necessary to provide for the safety of the victim and any family or household member;

(b) confiscating the weapon or weapons involved in the alleged domestic violence;

(c) making arrangements for the victim and any child to obtain emergency housing or shelter;

(d) providing protection while the victim removes essential personal effects;

(e) arrange, facilitate, or provide for the victim and any child to obtain medical treatment; and

(f) arrange, facilitate, or provide the victim with immediate and adequate notice of the rights of victims and of the remedies and services available to victims of domestic violence, in accordance with Subsection (2).

(2)(a) A law enforcement officer shall give written notice to the victim in simple language, describing the rights and remedies available under this chapter, Title 30, Chapter 6, Cohabitant Abuse Act, and Title 78, Chapter 3h, Child Protective Orders.

(b) The written notice shall also include:

(i) a statement that the forms needed in order to obtain an order for protection are available from the court clerk's office in the judicial district where the victim resides or is temporarily domiciled;

(ii) a list of shelters, services, and resources available in the appropriate community, together

Appendix A: Utah Health Code

with telephone numbers, to assist the victim in accessing any needed assistance; and

(iii) the information required to be provided to both parties in accordance with Subsection 77-36-2.5(7).

Utah Code: Cohabitant Abuse Act

30-6-1. Definitions.

As used in this chapter:

(1) "Abuse" means intentionally or knowingly causing or attempting to cause a cohabitant physical harm or intentionally or knowingly placing a cohabitant in reasonable fear of imminent physical harm.

(2) "Cohabitant" means an emancipated person pursuant to Section 15-2-1 or a person who is 16 years of age or older who:

(a) is or was a spouse of the other party;

(b) is or was living as if a spouse of the other party;

(c) is related by blood or marriage to the other party;

(d) has one or more children in common with the other party;

(e) is the biological parent of the other party's unborn child; or

(f) resides or has resided in the same residence as the other party.

(3) Notwithstanding Subsection (2), "cohabitant" does not include:

(a) the relationship of natural parent, adoptive parent, or step-parent to a minor; or

(b) the relationship between natural, adoptive, step, or foster siblings who are under 18 years of age.

(4) "Court clerk" means a district court clerk.

(5) "Domestic violence" means the same as that term is defined in Section 77-36-1.

(6) "Ex parte protective order" means an order issued without notice to the defendant in accordance with this chapter.

(7) "Foreign protective order" means a protective order issued by another state, territory, or possession of the United States, tribal lands of the United States, the Commonwealth of Puerto Rico, or the District of Columbia which shall be given full faith and credit in Utah, if the protective order is similar to a protective order issued in compliance with Title 30, Chapter 6, Cohabitant Abuse Act, or Title 77, Chapter 36, Cohabitant Abuse Procedures Act, and includes the following requirements:

(a) the requirements of due process were met by the issuing court, including subject matter and personal jurisdiction;

(b) the respondent received reasonable notice; and

(c) the respondent had an opportunity for a hearing regarding the protective order.

76-5-102. Assault.

(1) Assault is:

(a) an attempt, with unlawful force or violence, to do bodily injury to another;

(b) a threat, accompanied by a show of immediate force or violence, to do bodily injury to another; or

(c) an act, committed with unlawful force or violence, that causes bodily injury to another or creates a substantial risk of bodily injury to another.

(2) Assault is a class B misdemeanor.

(3) Assault is a class A misdemeanor if:

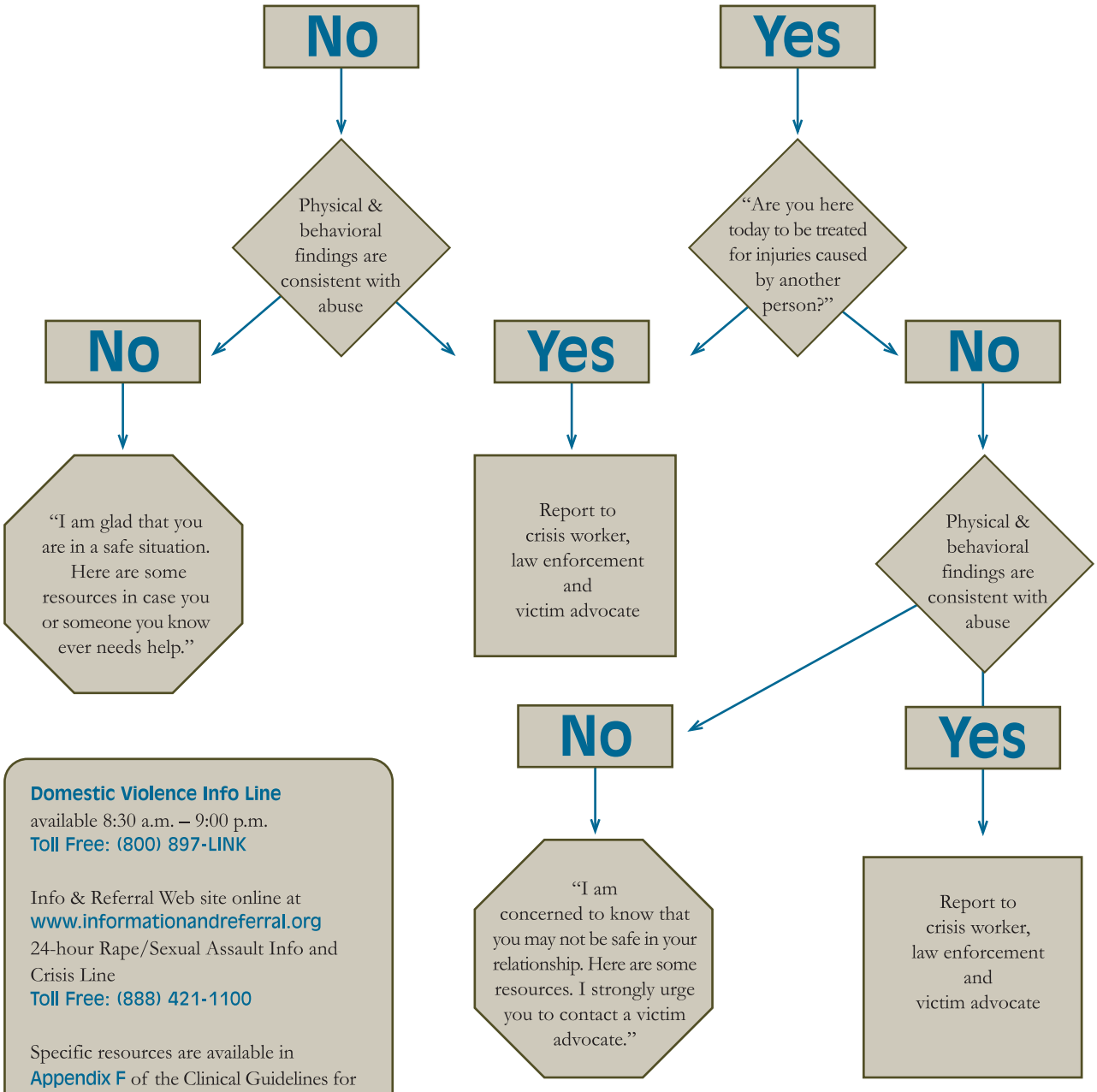
(a) the person causes substantial bodily injury to another; or

(b) the victim is pregnant and the person has knowledge of the pregnancy.

(4) It is not a defense against assault, that the accused caused serious bodily injury to another.

Appendix B - Assessment and Decision Tree

"I ask all patients if they are in a relationship or in a home with someone who may be hurting or controlling them. Are you in a relationship with someone who physically hurts or threatens you?"



Domestic Violence Info Line
available 8:30 a.m. – 9:00 p.m.
Toll Free: (800) 897-LINK

Info & Referral Web site online at
www.informationandreferral.org
24-hour Rape/Sexual Assault Info and Crisis Line
Toll Free: (888) 421-1100

Specific resources are available in **Appendix F** of the Clinical Guidelines for Assessment & Referral for Victims of Domestic Violence Reference Manual for Health Care Providers

No one deserves to be abused. Ask the question and offer domestic violence resources to all female patients age 14 or older. Reinforce the option for the patient to return at any time for further information and available resources.

Appendix C - Danger Review

A review of dangerousness is a difficult and uncertain task and it cannot predict if a domestic violence perpetrator will or will not seriously harm or kill his/her partner or others. The following is only a guide.

Has the perpetrator verbally threatened to kill or harm the victim, children, or others?
Has the perpetrator threatened to harm or kill himself/herself, or has he/she exhibited fantasies or detailed plans of suicide and/or homicide?
Does the perpetrator possess weapons and has he/she threatened the victim or actually used them in abusing the victim or others?
Has the perpetrator injured the victim, children, or others seriously enough to require medical treatment?
Does the perpetrator have a criminal history of violence or stalking behaviors?
Is the perpetrator intoxicated on a daily or weekly basis or does he/she heavily or regularly use amphetamines, heroin, or other street drugs, and/or does the perpetrator become violent when abusing substances?
Has the perpetrator violated a protective order in the past?
Has the domestic violence increased in severity and frequency over the past year?
Has the perpetrator forced sexual activities upon the spouse or children?
Has the perpetrator ever prevented the victim or children from leaving by threatening physical harm to self or others if they leave?
Has the victim recently separated from or terminated the relationship with the perpetrator?
Has the perpetrator harmed or killed family pets or threatened to do so?
Has the perpetrator destroyed the victim's personal property?
Has the perpetrator dropped out of treatment or been non-compliant in a domestic violence treatment program?
Does the perpetrator exhibit excessive jealousy?

Adapted from Lethality Review by Dan Greene, LCSW and the Treatment Sub-committee of the Salt Lake Advisory Domestic Violence Committee.

Appendix D - Assessment Checklist for Victims of Domestic Violence

Interview the victim separately from the partner or other family members.

Risk Factors: (check all that apply)

- ☐ Financial problems, unemployment
- ☐ Divorce or separation (especially during pregnancy)
- ☐ Substance abuse by victim or abuser
- ☐ Victim or abuser physically abused as a child
- ☐ Overly protective or controlling abuser (refuses to leave room)
- ☐ Suicide attempts by victim or abuser
- ☐ Mental illness of victim or abuser

Signs of Physical Abuse: (check all that apply)

- ☐ Self-induced or attempted abortions; multiple therapeutic abortions
- ☐ Multiple miscarriages
- ☐ Abdominal or pelvic injuries, back or spinal injuries (not from fall or MVA)
- ☐ Injuries to face, neck, throat, chest, breasts
- ☐ Injuries during pregnancy
- ☐ Increased drug/alcohol abuse during pregnancy
- ☐ Multiple injuries in various stages of healing
- ☐ Injury inconsistent with history
- ☐ Delay in seeking medical treatment
- ☐ Minimizes frequency and seriousness of injuries
- ☐ Repeated emergency department visits
- ☐ Sexual assault by partner
- ☐ Suicide attempt
- ☐ Single car crash
- ☐ Fractures in various stages of healing
- ☐ Burn (cigarette, friction, splash, chemical)
- ☐ Head injuries
- ☐ Low self-esteem, sense of apprehension or hopelessness, depression (laughing inappropriately, crying, no eye contact, angry, defensive)

Homicidal Risk: (check all that apply)

- ☐ Presence of gun in home
- ☐ Abuser threatened to kill victim or victim believes abuser may kill him/her
- ☐ Overly jealous
- ☐ Violent behavior by abuser toward non-family members
- ☐ Use of alcohol or drugs by abuser
- ☐ Increasing severity of injuries
- ☐ Abuser has killed pets
- ☐ Abuser objectifies victim

Used with permission. Deborah Haack, Injury Prevention and Control Program, Colorado Department of Health. Reprinted from Colorado Department of Health "Suggested Protocols for Victims of Spousal or Elder Abuse."

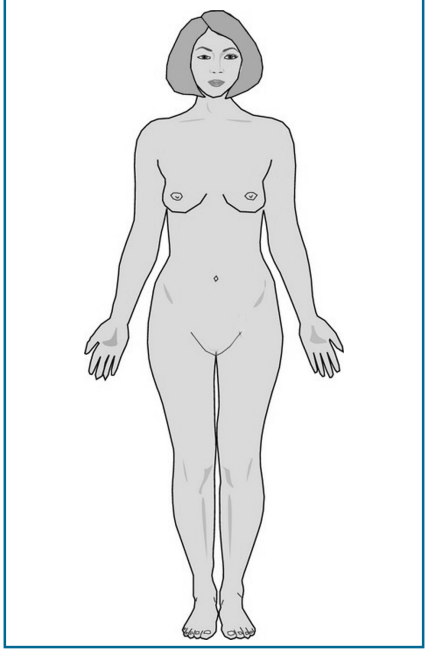
Appendix E - Domestic Violence Screening/Documentation Form

DV Screen
☐ DV + (positive)
☐ DV? (suspected)

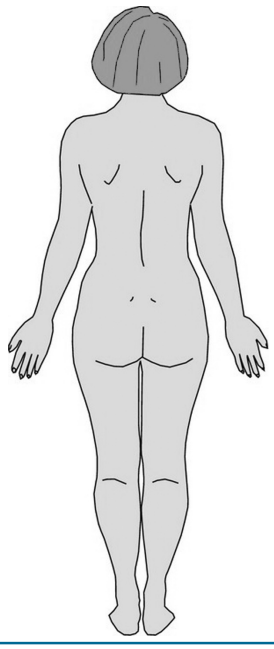
Date_____ Patient ID#_____

Provider Name: _____
Patient Pregnant? ☐ Yes ☐ No

Front



Back



Assess Patient Safety

☐ Yes ☐ No Is abuser here now?
☐ Yes ☐ No Is patient afraid of partner?
☐ Yes ☐ No Is patient afraid to go home?
☐ Yes ☐ No Has physical violence increased in severity?
☐ Yes ☐ No Has the abuser threatened to kill?
☐ Yes ☐ No Is patient suicidal?
☐ Yes ☐ No Is there a gun in the home?
☐ Yes ☐ No Is there evidence of alcohol or substance abuse?
☐ Yes ☐ No Was safety plan discussed?

Referrals

☐ Hotline number given
☐ Victim advocate referral made
☐ Shelter number given
☐ In-house referral made
Describe:_____
☐ Other referral made
Describe:_____

Reporting

☐ Law enforcement report made: Time____
Agency Name_____
Phone #_____ Spoke w/_____
☐ Child Protective Services report made
☐ Adult Protective Services report made

Photographs

☐ Yes ☐ No Consent to be photographed?
☐ Yes ☐ No Photographs taken? Attach photos and consent form.

Appendix F - Community Resources

Victim Advocate Programs Statewide

For more information or an updated list call toll free: **(800) 897-LINK (5465)**

Beaver County
Beaver County Sheriff's Office
Victim Advocate Program
2160 South 600 West
Beaver, UT 84713
(435) 438-6494

Box Elder County
YWCA, Box Elder County
P.O. Box 756
Brigham City, UT 84302
877-723-5600

Cache County
Cache County Victim Services
11 West 100 North, Suite C
Logan, UT 84321
(435) 716-8373

Carbon County
Carbon County Sheriff's Office
Victim/Witness Assistance
240 West Main
Price, UT 84501
(435) 636-3250 Or
(435) 636-3251

Daggett County
Refer to Uintah County

Davis County
Davis County Attorney's Office
Victim of Crime Assistance
800 West State Street
Farmington, UT 84025
(801) 451-4341

Layton City
Layton City Attorney's Office
Victim of Crime Assistance
437 North Wasatch Drive
Layton, UT 84041
(801) 546-8539

Duchesne County
Duchesne County Attorney's Office
Victim Advocate Program
255 South State Street
Roosevelt, UT 84066
(435) 722-0828

Emery County
Refer to Carbon County

Garfield County
Refer to Iron County

Grand County
Grand County Attorney's Office
Victim Advocate Program
125 East Center Street
Moab, UT 84532
(435) 259-1384

Iron County
Iron County Attorney's Office
Victim Services
95 North Main, Suite 26
Cedar City, UT 84720
(435) 865-6368

Juab County
Refer to Sevier County

Kane County
Kane County Sheriff's Office
Victim Services
76 North Main Street
Kanab, Utah 84741
(435) 644-4989

Millard County
Millard County Attorney's Office
Victim Advocate Program
765 South Highway 99, Suite 3
Fillmore, UT 84631
(435) 743-6522

Morgan County
Refer to Weber County

Piute County
Refer to Sevier County

Rich County
Refer to Cache County

Salt Lake County
Draper City Police Dept.
Victim Advocate Program
12441 South 900 East
Draper, Utah 84020
(801) 576-6355

Midvale City
Midvale City Police Dept.
Victim Advocate Program
7912 South Main Street
Midvale, UT 84047
(801) 256-2505

Appendix F - Community Resources

Victim Advocate Programs Statewide

Murray City
Murray City Police
Victim Advocate Program
5025 South State Street
Murray, UT 84107
(801) 284-4203 or
(801) 284-4201

Salt Lake City
Victim Resource Center
320 East 200 South
Salt Lake City, UT 84111
(801) 799-3756

Salt Lake County
Salt Lake County Sheriff's Office
Victim Advocate Program
3365 South 900 West
Salt Lake City, UT 84119
(801) 743-5860 or
(801) 743-5861

Sandy City
Sandy City Police Dept.
Victim Advocate Program
10000 South Centennial Parkway
Sandy, UT 84070
(801) 568-7283 or
(801) 568-6059

South Jordan
South Jordan Police Dept.
Victim Advocate Program
11175 South Redwood Rd.
South Jordan, UT 84095
(801) 254-4708, Ext. 216

South Salt Lake City
South Salt Lake Police Dept.
Victim Advocate Program
2835 South Main
South Salt Lake, UT 84115
(801) 412-3660

West Jordan City
West Jordan Public Safety Dept.
West Jordan Victim Advocate Program
8000 South 1700 West
West Jordan, UT 84088
(801) 566-6511

West Valley City
West Valley City Attorney's Office
Victim Advocate Program
3375 South Market Street
West Valley, UT 84119
(801) 963-3223

San Juan County
San Juan County Sheriff's Office
Victim Advocate Program
P.O. Box 788
Monticello, UT 84535
(435) 587-2237 or
(435) 459-1819

Sanpete County
Refer To Sevier County

Sevier County
New Horizons Crisis Center
Richfield, UT 84701
800-343-6302

Summit County
Summit County Attorney's Office
Victim Assistance Program
6300 North Silver Creek Rd.
Park City, UT 84098
(435) 615-3850

Tooele County
Pathways
Tooele County Shelter
(435) 843-1645 or
(800) 833-5515

Uintah County
Vernal Police Dept.
Victim Advocate Program
437 East Main Street
Vernal, UT 84078
(435) 789-4250

Utah County
Alpine/Highland Police Dept
Victim Advocate Program
20 North Main
Alpine, UT 84004
(801) 756-9800

American Fork Police Dept.
Victim Advocate Program
98 North Center Street
American Fork, UT 84003
(801) 763-3020

Lehi City
Victim Advocate Program
150 North Center Street
Lehi, UT 84043
(801) 768-7117

Appendix F - Community Resources

Victim Advocate Programs Statewide

Orem City
Orem Dept. of Public Safety
Victim Assistance Program
95 East Center
Orem, UT 84057
(801) 229-7128

Pleasant Grove
Pleasant Grove Police Dept.
87 North 100 East
Pleasant Grove, UT 84062
(801) 785-3506

Provo City
Provo City Police Dept.
Victim Advocate Program
351 West Center Street
Provo, UT 84603
(801) 852-6375 or
(801) 852-6280

South Utah County
South Utah County Victim Advocate
439 West Utah Ave.
Payson, UT 84651
(801) 465-5224

Springville/Mapleton
Springville Police Dept.
Victim Advocate Program
45 South Main
Springville, UT 84663
(801) 489-9421 (ask for advocate)

Utah County Sheriff's Office
Victim Assistance Program
3075 North Main
Spanish Fork, UT 84660
(801) 343-4336

Wasatch County
Wasatch County Attorney's Office
Victim Assistance Program
55 South 500 East
Heber, UT 84032
(435) 657-3300

Washington County
DOVE Center
P.O. Box 2972
St. George, UT 84771
(435) 628-0458

Wayne County
Refer to Sevier County

Weber County
Weber County Sheriff's Office
Victim Advocate Program
2380 Washington Blvd., #G11
Ogden, UT 84401
(801) 399-8065

Weber County Attorney's Office
Victim Assistance Program
2380 Washington Blvd, Suite 230
Ogden, UT 84401
(801) 399-8377

Federal Victim/Witness Program
(800) 949-9451

Department of Corrections
Victim Services Program
(801) 545-5899

Utah State Board of Pardons
Victim Assistance Program
(801) 261-6464

Attorney General's Office
Victim Services Unit
(801) 366-0223

Appendix F - Community Resources

Domestic Violence Shelters Statewide

Blanding
San Juan County Program
P.O. Box 423
Blanding, UT 84511
Crisis: (866) 206-0379

Brigham City
Your Community in Unity
435 East 700 South
Brigham City, UT 84302
(435) 723-5600

Cedar City
Canyon Creek Women's Crisis Center
P.O. Box 2081
Cedar City, UT 84721
(435) 865-7443

Davis County
Safe Harbor
P.O. Box 772
Kaysville, UT 84037
(801) 444-9161

Logan
Community Abuse Prevention Services Agency (CAPSA)
P.O. Box 3617
Logan, UT 84323-3617
(435) 753-2500

Moab
Seekhaven
P.O. Box 729
Moab, UT 84532
(800) 421-1100

Ogden
YCC of Ogden/Northern Utah
2261 Adams Avenue
Ogden, UT 84401
(801) 392-7273

Park City
Peace House
P.O. Box 682141
Park City, UT 84068
(435) 647-9161

Price
Colleen Quigley Women's Center
475 West Price River Drive
Price, UT 84501
(435) 637-6589

Provo
Center for Women and Children in Crisis
P.O. Box 1075
Provo, UT 84603
(801) 377-5500

Richfield
New Horizons Crisis Center
145 East 100 North
P.O. Box 9
Richfield, UT 84701
(800) 343-6302

Salt Lake City
YWCA Women In Jeopardy
322 East 300 South
Salt Lake City, UT 84111
(801) 537-8600

St. George
DOVE Center
P.O. Box 2972
St. George, UT 84771
(435) 628-0458

Tooele
Pathways
305 North Main
Tooele, UT 84074
(800) 833-5515

Vernal
Women's Crisis Shelter
1052 West Market Drive
Vernal, UT 84078
(435) 781-2264

West Jordan
South Valley Sanctuary
P.O. Box 1028
West Jordan, UT 84084-7028
(801) 255-1095

Appendix F - Community Resources

Utah Rape Crisis Programs

Statewide, toll-free
(888) 421-1100

Brigham City
Serves Box Elder County
Your Community In Unity (YCU)
(435) 723-5600

Cedar City
Serves Iron, Beaver, Kane, and Garfield Counties
Canyon Creek Women's Crisis Center
(435) 867-6149

Davis
Serves Davis County
Safeharbor
(801) 444-9161

Logan
Serves Cache and Rich Counties
Community Abuse Prevention Services Agency
(435) 753-2500

Moab
Serves San Juan, Emery, and Grand Counties
Seekhaven
(435) 259-2229

Ogden
Serves Weber and Morgan Counties
Your Community Connection (YCC)
(801) 392-7273

Park City
Serves Summit County
Summit County Victim Advocate Program
(435) 615-3850

Provo
Serves Utah, Wasatch, Carbon, and Juab Counties
Center For Women and Children in Crisis, Sexual Assault Services
(801) 356-2511

Richfield
Serves Sevier, Wayne, Piute, Millard, and Sanpete Counties
New Horizons Crisis Center
(435) 896-9294

St. George
Serves Washington County
DOVE Center
(435) 628-0458

Salt Lake City
Serves Salt Lake, Tooele
Rape Recovery Center
(801) 467-7273

Vernal
Serves Uintah, Daggett, and Duchesne Counties
Vernal Victim Advocacy
(435) 789-4250